PCMH FAQs 2016

October 2016

1. Will my practice fail if No is answered to the following question? Does your practice have the capability to submit data electronically to immunization registries or immunization information systems?
   - No, the practice will not fail for answering no to this question because it is realized that not all practices have this capability.

2. Activity H: There are three EHR/Immunization questions in the AHIN portal related to this metric. Are there negative consequences if practices cannot do any of these things, i.e. answers No?
   - Practices should be able to complete at least one of the items listed for this activity. If they cannot at this time, then they will need to submit a QIP describing their plans for meeting the activity.

3. If we have a new provider join our practice during the PCMH performance period, will we have to choose 10% HPB of his/her caseload?
   - No, additional HPBs will not be chosen.

September 2016

- No Facts

August 2016

1. Our performance report reveals that we passed 6-month validation, however, it indicates the 24/7 access to care was not submitted. I confirmed that it was attested to in AHIN. Why is there conflicting information?
   - There’s a small note at the end of the activity summary “Practice Support Activities C-G are currently being validated. Activities that are pending validation are displayed with a red X.”

2. After reviewing the data requested from HP, it was confirmed that beneficiaries with a primary insurance and Medicaid secondary are included in my denominator, but my numerator doesn’t reflect a visit when a well-child exam is performed. Will these be excluded from my denominator?
• A partial payment from Medicaid secondary is required for it to be captured in your metrics (numerator). Credit for the beneficiaries that received service and reimbursed by primary insurance only will be given. Documentation from the clinic confirming the provided service will be required.

3. Some EMRs put BMI 30-15 in the problem list. Is the wide range of “BMI 30-15” documentation in the care plan enough for the “assessment” or does it need to be addressed as stable, unstable, etc.?

• The manual states: “Documentation and assessment of each problem (stability or change of the condition)” If the EHR includes this in the problem list and it is an abnormal finding, documentation should address it.

4. My PCMH report shows that my point in time attributed beneficiaries are not being captured in my 6-month beneficiary attribution. Can you explain why?

• 6-month attribution is based off 6 paid PCCM claims during a 6-month run out. Point in time is based off of how many beneficiaries are actively attributed through the PCCM program. If the PCCM designation is not to the provider’s individual Medicaid number or the group number for the PCMH clinic, 6-month attribution will not be generated.

**July 2016**

1. If a practice remediates their 2015 practice support metrics during the stated timeframe, will they become eligible to claim shared savings if their number increases to a passing rate and their pool qualifies?

• If a practice successfully remediates their practice support metrics and their pool is eligible for shared savings then yes, they will be eligible to receive shared savings payout at the time of reconciliation.

2. Will beneficiaries with Blue Cross, UHC, Qualchoice etc. as their primary insurance and Medicaid as their secondary insurance be included in the metrics and the PCMH program?

• TPL (third party liability) clients count in the point in time and PBPM calculations however the presence of a TPL claim excludes that beneficiary from 6month attribution and ultimately from Metric calculations and TCOC.

3. Regarding Metric 6: Can you confirm that the following ICD codes are inclusive of all the diagnosis codes for this measure?
2013 HEDIS ICD-9 codes:
493.0, 493.1, 493.8, 493.9
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

- The codes provided are all the codes included in the metric.

4. If a provider utilizes a well-child code visit, and that provider is NOT one of our PCMH practice PCPs – will that count in any of the well child visit metrics? Or does the well child visit have to be completed by one of our PCMH practice providers?

- The well child visit does not have to be performed by a PCP associated with a PCMH to count towards the numerator. For each beneficiary identified in the denominator, we verify that they had a ICD, CPT, or HCPCS code that identifies that they had a wellness visit.

5. Regarding Metric 2: Are newborns counted in the 10 day follow up?

- See slide 10 of the 2014/2015 PCMH Policy Program Addendum for excluded childbirth/newborn codes from this metric, and additional preventative codes to capture additional services performed by the physician (specifically targeting pediatric care).

6. 2016 Care Plan Validation: At what rate (percentage) will care plans be validated at for 2016 and will this be at the provider level or the clinic level?

- The goal should be 100% passing submission. QA will be using the same methodology as last year to select care plans with the exception of excluding care plans that were previously selected.

**June 2016**

**Reports**

1. How often is the patient panel updated in AHIN?

- Quarterly
Activities/Metrics

2. In regards to Activity E Medical Neighborhood Barriers
   If we don't have any barriers with hospitals and/or specialists, is it appropriate for attestation/validation purposes to simply state that in the portal?
   - There are always barriers, regardless of significance. However, if there isn’t a recognizable barrier “no barriers are identified” would be acceptable.

3. There are some clinics that are truly open access, every patient who requests to be seen same day are offered an appointment with either a mid-level provider or physician. Therefore, they do not have any "unfulfilled requests." Will a written policy describing the open access work for validation purposes? Or do they still have to have a "tool"?
   - If the clinic is open access, without any unfulfilled requests using a tool is not necessary. The tool is to help identify barriers to same day access. A written policy of their process is adequate.

4. In the AHIN Portal, it asks "Do you use a tool to measure and monitor same-day appointment requests on a daily basis?" Does it suffice if a practice has a written policy where fulfilled appointments are recorded in their practice management/scheduling software daily; and the appointment schedule is printed once a month at the beginning of business and again at the close of business to monitor access? Or does this have to be printed daily?
   - If they have their process documented and written policy recorded daily, it would be sufficient to print monthly.

5. Could you please advise on the following items? For the three EHR/Immunization questions in the AHIN portal:

   Are you able to document historic immunization data in your EHR?  Yes  No
   a) Does this mean can you open a patient chart and add historical immunization completion dates to a patient record? For example, either by patient report or if patient brings in a document from the health department?
      - Yes, that is correct.

   Are you able to review historic immunization data at each visit?  Yes  No
   b) Does the historical review have to be done in the practices EHR, through WebIZ, or either?
• The “and review on each visit” is making reference to the “historic data” you entered in to your EHR. So it is asking from your EHR and NOT WebIZ.

*Does your practice have the capability to submit data electronically to immunization registries or immunization information systems? Yes No*

c) Does this mean typing in data electronically using computer, OR do you mean to say can you push (feed) data automatically to WebIZ or other IS system (no manual data entry)?

• This does NOT mean manual entry to WebIZ or immunization information systems

6. **“Instructions for follow up.  The documentation should include the timing of a future follow up-visit (related to the problem.)”**

a) Does EACH problem need a follow up? This would appear to be duplicative documentation. If all problems need instructions for follow up, can a provider not say “Follow up for all problems in 3 months,” or “Follow up for chronic problems in 6 months” for example?

• Providers aren’t expected to document a follow up for each problem. One statement for instructions for follow up will meet the requirement. For example, stating “follow up in six months” will suffice.

b) Does wording matter? For example, will “Follow up in 1 year for WCC” be as accurate as “Follow up yearly for WCC”?

• No, wording does not matter as long as it identifies the timing of a future follow up. Stating “follow up as needed” will not pass the requirement.

7. **“Assessment of progress to date: documentation and assessment of each problem (stability or change in condition).”**

a) What does “documentation of each problem” imply?

• It means that each active, significant/chronic problem is identified.

b) Documentation could simply be the writing down of problems, so will the problem list suffice for this. If not, what is really needed?
• Yes, a problem list will suffice.

c) Doesn’t “assessment”, with the following ( )’s mean that the clinician needs to address the stability of the problem or any change in condition?

• Yes, that is correct.

d) If so, will “Asthma, well controlled” not suffice?

• Yes, that will suffice.

8. In regards to AHIN, does the data that has been “saved” in the portal automatically get pulled on the attestation deadline or is it only those practices who hit “save” AND “submit?”

• The providers will need to select both Save AND Submit.

May 2016

Activities/Metrics

1. Activity D:
   We would like to clarify if the PCMH has to use “PCMH Change Concepts” as defined by the assessment survey they completed or can it simply be 3 improvement plans for care coordination and practice transformation.

   • The survey is simply used as a tool to help practices identify opportunities for improvement. Identifying opportunities to improve care coordination/practice transformation should be sufficient regardless of how the need for improvement is identified.

2. Activity F: Can you please clarify how practices who do not use an answering machine should answer the following question in AHIN: If employing an answering machine with recorded instruction for after-hours callers, do you regularly check to ensure 1. The machine functions correctly and 2. Instructions are up to date?
Although there are other processes sufficient to meet this requirement (i.e. answering services etc.), the question in AHIN references “answering machines” specifically. If you are meeting this requirement in other ways, check yes and provide documentation of your process in your binder to show during validation if needed.

3. In a practice with several providers, is it acceptable for the clinic to submit more than one format of care plans when it is time for care plan validation? For example, 5 of the 7 providers use their SOAP note for care plan; but 2 of the 7 use a separate care plan template. Is this acceptable?

- If their care plans include all required components, it shouldn’t matter what format they are using.

**April 2016**

1. Activity L: Join SHARE or participate in a network that delivers hospital discharge information to practice within 48hrs. Is it required to be enrolled in SHARE to meet this metric?

- The 2016 PMCH Program Policy Addendum states the following:
  - If a practice has not joined SHARE, indicate if the practice participates in a network that delivers hospital discharge information to practice within 48 hours.
  - Provide a description of the network the practice participates in that delivers hospital discharge information to the practice.
  - Practice must document compliance by written report to DMS via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

2. How do I add or remove a provider from our PCMH clinic? How do I update the PCMH contact information for our clinic?

- Both scenarios require an update/change form to be completed and submitted to ARKPII@hpe.com. This form can also be found on the payment initiative website.

3. What are the Arkansas Medicaid PCMH requirements for a clinic that is enrolled with CPC?

- The 2016 PCMH Program Policy Addendum states the following:
CPC practices must comply with all quality metrics tracked for shared savings incentive payments requirements, with the exception of Metric 1, which is excluded from metric compliance calculations for CPC practices. Achievement of targets for Quality Metrics 13, 14, and 15 can be calculated only if data required under Activity P is submitted through the AHIN Provider Portal. Failure to provide the required data will cause failure to meet targets for Quality Metrics 13, 14, and 15.

March 2016

Activities/Metrics

1. For the HPB metric that requires 2 visits per year, MUST the visit be performed by the PCP/physician? Is it acceptable for the mid-level (APN/PA) to see the patient for these visits and file the claim under the physician’s Medicaid ID#?

   • An MD must sign off on the note and care plan twice a year.

2. The following metric is listed % of beneficiaries 12-21 years of age who received one or more well-care visits during the measurement year. The Medicaid manual shows coverage for ARKids A through the age of 20 and ARKids B through the age of 18. How can we be evaluated for a service that Medicaid doesn’t provide reimbursement for?

   • DMS will revise this metric’s age range to 12-20

Shared Savings

3. Are the following services included in the Total Cost of Care for PCMH?

   • RSPMI (Rehabilitative Services for Persons with Mental Illness)
     Included
   • First Connections Program (Often referred to as Early Intervention)
     Not Included
   • DDTCS (Developmental Day Treatment Clinic Services)
     Not Included
   • CHMS (Child Health Management Services)
     Not Included
High Priority Beneficiaries (HPB)

4. On the HPB selection screen on the portal, the following is one of the messages (data tags) around HPB selection: # number of beneficiaries outside of risk score. What does this mean and does the provider have to do anything if they have a number > 0 in that field?

- This field is to alert providers that they have selected a beneficiary that has a low risk score and is not considered “high risk” by risk score valuation.

February 2016

Activities/Metrics

1. If a practice can produce eCQM results for “diabetes poor control” and “BP control for patients with HTN” does this meet the 24-month data extraction activity requirement?

- Yes, if a practice can produce an ECQM report for “diabetes poor control” and “BP control for patients with HTN” the report will meet the 24-month data extraction activity requirement.

2. Can an EPSDT and sick visit be performed the same day and be reimbursed for services?

- Yes, please follow up with your AFMC Outreach Specialist if you need assistance or have further questions.

3. Must returning practices complete a new PCMH Assessment during 2016 to pass the by June 30th deliverable or just attest that they did it for the 24-month deliverable?

- Practices should complete a new assessment for the six-month activity.
4. Instruction on the AHIN portal for 3-month activities says “If any of the above methods cannot be used to produce a report, please describe your process for computing the N/D:”, which implies that if a practice cannot produce N/D through a qualified CQM derived by the system, that an alternative method should be used for calculating N/D. For a practice who’s EHR cannot produce actual CQM’s for a given measure, should they derive N/D by other means (e.g., by calculating their own answers, not derived by the system) or should they just enter 0/0 with explanations stating that ‘system cannot produce measure’?

- Regarding the 3-month activity, the practice should enter a N/D if they have the ability to calculate actual CQM’s for a given measure by any means (e.g., calculating from EHR or by calculating their own answers, not derived by the system) and include explanations stating that ‘system cannot produce measure’?

Reports

5. What are the 2016 pre-set state cost thresholds?

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<th>2014</th>
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